DKH DAY KIMBALL HEALTHCARE

DEARY MEMORIAL CANCER FUND
Screening Sheet

Date: _____

Personal Information:

Name:_____
Last **First** **Mid Initial** **Maiden**

Address:_____
Street **Town** **Zip Code**

Telephone #: Home:_____ **Work:** _____ **Cell:**_____

Date of Birth: _____/_____/_____ **Age:** _____ **SS #:** _____

Eligibility Requirements:

( ) Yes ( ) No Individual resides in Northeastern Connecticut (13 towns served by Day Kimball Hospital)

( ) Yes ( ) No Individual is an outpatient or receiving inpatient chemotherapy.

( ) Yes ( ) No Individual has a primary care physician with privileges at Day Kimball Hospital

( ) Yes ( ) No Physician has determined the need for the service

( ) Yes ( ) No Individual has no insurance or has co-insurance with a high deductible or co-payment

( ) Yes ( ) No Maximum assistance of $5,000 per year, renewable annually

( ) Yes ( ) No Individual meets American Cancer Society Guidelines

Individual is eligible for
Day Kimball Hospital
Deary Memorial Cancer Fund

( ) Yes ( ) No

Approved Amount $_____

REV 1-2014